ASSOCIATION OF SAFETY-NET COMMUNITY HOSPITALS

comments regarding

Concept Paper for an 1115 Waiver for Illinois Medicaid

November 25, 2013

The Association of Safety-net Community Hospitals ("ANSCH") submits the following comments to The Path to Transformation: Concept Paper for an 1115 Waiver for Illinois Medicaid (the "Concept Paper").

Our Association was organized to inform government entities and elected officials of the specific mission and needs of safety-net community hospitals in Illinois. Our mission is critical because, with very limited exceptions, we serve only the neediest members of society.

Safety-net hospitals account for approximately 25% of all Medicaid days state-wide and approximately 37% of all Medicaid days in the City of Chicago. If public charity hospital services are excluded, our percentage of Medicaid days in the City increases to approximately 43%. Individually, some of our members are over 60% Medicaid. Clearly, by any definition, we serve a "disproportionate" share of our State's Medicaid clients.

Safety-net hospitals are themselves needy because we have limited opportunity, if any, to cross subsidize with commercial business; yet face daunting financial pressures from rising costs (principally labor, pharmaceuticals, and malpractice coverage), significant charity care, an aging infrastructure, downward pressure on revenues and the need to keep pace with technology.

Among the critical issues safety-net hospitals face are the following:

1. Lack of capital for facility, technology, life safety, and equipment improvement and/or replacement;
2. As we approach implementation of the Affordable Care Act, increasing numbers of uninsured and underinsured patients, including undocumented patients for whom there is no reimbursement source;
3. Disparity of cost vs. payment in Medicaid and Medicare funding;
4. Difficulty in recruiting and retaining staff physicians due to low payments and high malpractice, including the need to subsidize some specialities just to offer services;
5. Increased incidence of disease and complications due to lack of primary care access;
6. Difficulty in recruiting and retaining staff due to financial, benefit, and community safety conditions;
7. Increased mortality and morbidity due to lack of specialty care referrals;
8. Cost of providing cultural and language appropriate treatment and care management;
9. Increased education, medication, and follow up needs due to lower community health indexes; and
10. Decrease in or total inability to cost shift from better payment insured patients.

We applaud the state's efforts to improve the Medicaid delivery system with increasing reliance on care integration and related efforts to attract "federal investments" therefor. ANSCH, and its members individually, have been in the forefront of care integration through investment in Family Health Network and our relationships with FQHCs. We are also actively involved in efforts to establish CCE's and ACE's. On the financial front, we are continually pushing the envelope of maximizing Federal revenues through programs such as the hospital assessment program.

Although we support the general concepts set forth in the Concept Paper, we are concerned with the lack of discussion regarding implementation. Just as with the current headwinds facing the Affordable Care Act, there is a great deal at risk if implementation is not well conceived, well organized, well staffed and not unduly rushed. The administrative departments that will be tasked with implementation of the waiver are already stressed due to underfunding and understaffing.

With respect to specific sections of the Concept Paper, we wish to comment as follows:

At section 2A, the Concept Paper discusses various "new models of integrated service delivery". As discussed above, we are already actively engaged in this effort. Notwithstanding, we believe the Concept Paper must address the need for uniform operational standards. Such standards should include:

a. compliance standards and quality targets
b. MLR loss ratio of 90%
c. timely payments requirements
d. rate floors
e. shared savings standards
f. network prerequisites
g. performance bonds
h. dispute resolution protocols
i. utilization review/denials management

Further, there should be a stated preference for provider based, not-for-profits systems and any such systems should be granted automatic market entry if and when they meet defined standards. There also needs to be a systematic review of current regulations to insure that barriers to entry are revised or eliminated.

Section 2C discusses "Hospital/Health System Transformation". In our opinion, our industry is already well on the way to achieving many of the stated goals. It was the hospital industry that brought forward many of the innovations in the SMART Act, specifically including reducing readmissions. As discussed above, safety-net hospitals are already engaged in a variety of efforts to manage care, whether through investment in Family Health Network or through the creation of CCEs and ACEs.

While we applaud efforts to find additional resources dedicated to preserving the "safety-net", it is more important to avoid disruption to existing financing vehicles. At all cost, the hospital assessment program should be maintained and efforts to maximize UPL through additional enhancements to the assessment should be pursued. However, there is a current tension between the proposed shift to managed care and preservation of the assessment and the UPL. To that end, the waiver should ask for an exception to the rule that requires a reduction in the UPL for payments made by managed care entities. At the state level, the sunset of the current assessment should be eliminated. With these changes, there is no need to proposed new, untested funding alternatives. Further, we believe that subsequent enhancements to the hospital assessment can be use as the vehicle to create leveraged, capital funding.

As discussed in Pathway#4, we wholeheartedly support any and all efforts to enhance the number of healthcare workers, specifically including physicians and nurses. Further, we wholeheartedly support the emphasis on increasing primary care providers. Notwithstanding, among the reasons it is extremely difficult to attract qualified physicians and nurses to the inner city is the cost of malpractice insurance. To that end, not only is there a need to train more primary care doctors and nurses, we must find ways to induce them to serve in medically underserved areas.

Accordingly, the waiver must address malpractice/liability concerns similar to protection provided to FQHCs under federal tort statutes. To that end, protections should also extend to physicians, both employed and independent, and CCEs and ACEs associated with high volume Medicaid services.

In addition, consideration should be given to redistributing medical education funding to compensate for the training of physicians in community based settings. There is currently a mal-distribution under existing Federal policy detrimental to smaller training programs with less than 100 residents, such as those currently undertaken at safety-net hospitals.

Further, we must ensure that the Medicaid population, particularly behavioral health patients, continues to have access to prescription medications under the four-scrip policy and during the move to capitated, managed care. At a minimum, a 90-day grandfather clause should be required of MCOs during the transition from fee-for-service to a managed care entity. Pharmaceutical support for this population should be a consideration just like housing and employment. The Medicaid population we serve cannot lose access to prescription drugs.

Finally, in identifying projected savings through the various programmatic changes anticipated in the waiver, it is important that, to the extent possible, the savings realized stay within the Medicaid system. Illinois has a tradition of shorting healthcare to fund other general revenue fund requirements. With respect to hospitals, the state is currently funding less than 30% of the cost of providing Medicaid services. Illinois doesn't necessarily have a "cost" problem and, in fact, Medicaid spending has contracted in recent years above and beyond the SMART Act. Accordingly, implementation of the waiver cannot be used as an excuse for the state to further reduce its commitment to funding the health of its neediest populations.

Thank you for your consideration of our comments. Any questions or requests for additional information should be forwarded to our Chairman, Mark Newton. Address: Swedish Covenant Hospital, 5145 N. California, Chicago, 60625 Email: MNewton@schosp.org